CALMARE PAIN THERAPY PATIENT INITIAL EVALUATION

(Completed by Practitioner)

Patient Name _____ **Date:** _____

Chronic Pain Diagnosis (include dates and location of pain):

_____

Co-Morbidities(include date of diagnosis)

_____

_____

_____

Current Analgesic Regimen:

Drug Name	**Strength (eg, mg)**	**Frequency**	**Maximum Total Daily Dose**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How often is the pain present (circle answer)?

Constant (76 – 100%) Occasional (26 – 50%) Frequent (51 – 75%) Intermittent (25% or less)

Does patient have Allodynia? **YES** **NO**

If yes, describe (i.e.: touch, shower, breeze):

_____

Pain is USUALLY worse for patient?

Morning Afternoon Evening Night

Does anything make patient's pain BETTER? **YES** **NO**

If YES (describe): _____

Does anything make patient's pain WORSE? **YES** **NO**

If YES (describe): _____

_____

Signature of Practitioner Date